

Marriage Problems

Dealing with Them in Private Practice

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IN 1957 there were 38,333 marriages in Los Angeles County; and in the same year there were 32,563 divorce, separate maintenance and annulment suits filed.⁵ This is not fully indicative of the immensity of the problem, for there are no reliable data on the number of marriages saved from divorce by the death of a spouse or terminated by unofficial separation or desertion, or on the number of married persons who maintain a separate existence while living under one roof.

THE NEUROSIS OF OUR CULTURE

Marriage is not of itself the cause of neurosis. However, too often neurotic persons attempt the impossible: to escape from their own neurosis into happiness through marriage, which they hope will result if they leave a home situation, school, job or previous marriage in which they have been unhappy. Instead of living happily ever after, they have again to contend with their own neurotic personalities in new situations, perhaps now abetted by an equally neurotic spouse. Such a couple resembles two unhappy porcupines who, to escape the night's chill, huddle together for warmth, wound each other with their sharp quills, and separate; become chilled again, huddle again, wound each other again, and again move apart.

It must be emphasized that neurosis of the kind under discussion here—the kind that causes family conflict and which psychiatrists attempt to treat—is not inherited and is not the result of organic brain disease. It is a characteristic attitude and behavior, learned and acquired in the environment and culture in which the subject is reared and trained, and it becomes his unconscious personality and functioning. We must look to the family and to the larger society for its cause.²

Ours is not a stable and static society. There are manifold symptoms of disorganization and change, and the high incidence of marital conflict is only one of these. Others: a high crime rate, a mobile population, economic contradictions of inflation and depression, prosperity and insecurity. Our culture is a curious anomaly. It produces easy living, with gadgets, gimmicks and happiness pills, and an un-

• Marriages and divorces in Los Angeles County almost equal each other. Marriage per se is not the cause of neurosis. When two neurotic persons marry, the resulting neurotic interaction too often ends in conflict, broken homes and a new generation of neurotic children.

Psychotherapy must be related to the diagnosis of family psychopathology, should include all the involved members and should be directed toward the realistic goal of integrating them into family living.

Of 100 cases taken from the author's experience, 64 involved married couples and the majority of these had serious interspouse conflicts. In 37 cases both spouses were treated and substantial psychotherapy was given to one or both of the partners. It included one or more modalities varying from electroshock therapy, tranquilizers, and such psychotherapy as supportive, dynamic interpretive, individual, spouses together, group and hypnotherapy. Thirteen achieved clinical recovery, nine improved, twelve were still in therapy. In three cases therapy failed.

desirable side effect of ever greater numbers of neurotics. It produces superficial materialistic values which motivate the high school and college student to choose snap pseudo-social courses and become juvenile delinquents and intellectual beachcombers. These are symptoms, and in their turn, causes of disorganization and change.

Perhaps the most important single factor, both symptom and cause, is the all-prevailing manifest conflict in cultural values. Its effect is to confuse and disturb the individual when he has to select from the conflicting value-choices of his environment, frequently with the help of parents who are equally torn between spiritual ideologies and ethical standards on the one hand and keeping up with Joneses on the other. This is so well recognized by psychiatrists that the psychotherapy of children and adolescents is largely directed toward the psychotherapy of the parents, as they are the determining factors in the pathogenic environment and the illness.

FAMILY PSYCHOPATHOLOGY AND PSYCHOTHERAPY

To continue the usual genesis and complete the circle, the child, grown to an emotionally immature

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adult, marries, affects and is affected by the neurotic interaction in the new family unit.

A patient is often referred or comes to the psychiatrist for ostensibly somatic complaints, maladjustments to work situations or family conflicts. It is only after a careful history-taking that the mental illness producing conflicts in social situations and marriage becomes evident as the basic problem. Very often, the one who comes for therapy may not be the family member most in need of it. He may be the "presenting symptom," or the one with most insight, or perhaps the most submissive member, who has been referred to the psychiatrist as a sacrificial offering. Psychiatric patients come from mentally disturbed families. Therefore any psychotherapy adapted only to the patient's own personality problems will have only limited effect if the family interacting psychopathology is neglected and the patient continues his exposure in the family. Psychotherapy must be related to the diagnosis of group psychopathology and must be concerned with the development of goal-directed, culturally oriented, realistic, healthy values and attitudes. The aim is to integrate individuals into family living, not alienate them.

The clinical practice of medicine has evolved from merely treating symptoms to the more rational therapy of a person suffering from disease, and thence to the still more comprehensive scientific concept of preventive medicine, using such techniques as immunization and community hygiene. The clinical practice of psychiatry has similarly evolved from primitive punitive attitudes, to the more humane individual therapy of a person suffering from a mental disorder, to the more comprehensive understanding and treating of mental illness as the psychopathological interaction of the individual with his group, including spouse, siblings, parents and children.^{1,6}

Psychiatry is a developing science and among its practitioners are some who maintain a rigidly permissive attitude in relation to patients who resort to divorce. There are others equally dogmatic at the opposite extreme who require that their unhappily married patients continue so, until either death or psychosis intervenes. A more mature and pragmatic approach requires humane consideration for the patient, his immediate problem and how a solution will affect not only him but the whole family unit.

For the purposes of this communication, I reviewed the records of my latest one hundred patients and attempted a partial analysis and classification of those characteristics of the individuals, their problems and the therapy prescribed, which have a bearing on the subject matter.

Of the 100 patients the initial patient in 36 presentations was an unmarried person. In five of these

situations (in four of which the initial patients were teen-agers) a parent or parents became the main targets of the therapy. In the cases of 54 married patients, there was some therapy given to the other spouse in addition to the primary patient—minor supportive therapy in 17 cases and extensive therapy in 37. In nine of these situations, both spouses received substantial therapy, while in 22 the spouse other than the initial patient received some therapy. In only six of these family units did the other spouse refuse to accept any therapy, although he or she was nevertheless consulted and oriented as to the psychopathology and psychotherapy of the marital partner.

Of 64 married patients, 47 expressed overt hostility toward the other spouse at the first interview, five at subsequent interviews. Twelve were more subtle and veiled in their manifestations of hostility; there was no divorce threat in nine of these couples, and in three the spouses genuinely liked each other.

Treatment given to those who were given the more extensive therapy included the use of tranquilizing drugs, electroshock and psychotherapy. The latter ranged from supportive to analytic and sometimes included hypnotherapy. Some patients had individual treatment; in other cases both spouses were treated together and in others group psychotherapy was used. In some instances therapy was continued for only a few weeks, in others for several years and hundreds of sessions.

Thirteen of the 37 couples who underwent extensive psychotherapy reached what can be looked upon as "clinical recovery" in that they became able to dwell together amicably as husband and wife. Nine others had considerable improvement and at this writing 12 were still in therapy with promising indications. Three had no improvement.

In none of these cases was there any indication of fact to give basis to the unfounded charge that there is causal relationship between psychotherapy and subsequent divorce, promiscuity or other immature behavior.

PSYCHOTHERAPEUTIC MODALITIES

There are varied psychotherapeutic methods which can be used either singly or in combination—electric shock, chemotherapy and psychotherapy. Psychotherapy as now used refers particularly to the mental approach to the intellect and emotions. It may be supportive, dynamic interpretive or hypnotherapy. Psychotherapy also includes the manipulation and adjustment of the environment, the better to meet the patient's needs. This may require therapy of the group, including the spouse, parent or other dominant individual. Therefore a comprehensive

therapy for the individual as he functions in his environment may require the treatment of the individual alone, sometimes together with his spouse or other member of his family and sometimes in group psychotherapy with others, or a combination of these forms of treatment.

The first step is to establish rapport and empathy. Therapy begins with the initial greeting of the patient, a welcoming handshake and an invitation to a comfortable seat. A small but pertinent technique for establishing rapport may be the offering of a cigarette or the sharing of a piece of gum with the patient. It is like breaking bread together. Even though usually there is some information about the patient from the referring physician or family, the patient is asked to tell all about his problem or situation in his own words and in his own way. This helps to give the feeling that there has been no prejudgment of the patient or his problem. This applies equally to any member of the family who may be interviewed subsequently.

The patient is encouraged to ventilate his complaints and recriminative feelings against spouse, parent, children and others. Sometimes it is necessary to direct the discussion into more relevant channels. Care is taken not to suggest any condemnation or judgment. However, it is equally important in extending acceptance and empathy not to lead the patient to believe that he has the stamp of approval of all of his attitudes and conduct. The patient's revelations are then analyzed and interpreted, so that the patient is given insight into his immature attitudes and behavior, and at the same time is given some understanding of the immature retaliative behavior of those with whom he has neurotic interaction. This blunts many of the arrows in the cold and hot war between the spouses and leads to greater tolerance and empathy for each other.

Each individual, whether recriminative or self-degrading, is on the defensive. He has a feeling of guilt, inferiority, insecurity and anxiety. Each needs ego-building and relief from feelings of guilt, but not at the expense of the other spouse. Often, as a defense, he will say that marriage is a 50-50 proposition and that he had held up his end. And it must be pointed out to him that the 50-50 attitude falls short and will not bridge the needs of living together. He is made to understand that what is needed is all-out giving, without any holding back. Precept and practice must be brought into better perspective. He is helped to reexamine social codes, realities and the Joneses. Realistic compromises must replace narcissistic needs for perfection, and give motivation to salvaging marriages and families. It is a difficult and complex thing to be a human being, and human beings are not yet up to it.³

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Discussion by JOHN D. MORIARTY, M.D., Los Angeles

DR. RUSKIN has presented an interesting and comprehensive discussion of various phases of the practical management of marital problems encountered in the psychiatrist's private practice. He has properly laid emphasis on the neurotic interaction of the marriage partners.

It might not be amiss to point out that one of the major sources of difficulty is that in our society it frequently happens that two people of quite different cultural backgrounds marry. In such circumstances, even though they may genuinely love each other, they may have frequent clashes or disagreements about many things because of the different value systems and the different unconscious concepts of what marriage consists of—even though they reach a pretty good area of agreement about marriage on the conscious level.

A factor not specifically dealt with by Dr. Ruskin is that in our changing culture the role of the male and the role of the female have become distinctly blurred. Particularly with the developments in World War II—the increasing breakdown of the barriers between the masculine and the feminine role, and since then women going out and actively competing with men—there has been further confusion as to the separate identity of the two marital partners.

A further factor, which Dr. Ruskin did not discuss is the observation of Carl Jung that opposite personality types tend to marry. Thus, the extrovert tends to marry the introvert; the analytic, the intuitive. It seems safe to infer that this is Nature's way of trying to round out the progeny from a biological standpoint. Unfortunately, the very qualities which originally attracted the two partners to each other tend to become sources of conflict after the marriage. Thus the extrovert complains that his introverted wife does not like to have people in often enough and wants to be too much of a homebody. The person who tends to operate by analytic judgment complains that his intuitive wife is too "emotional." In other words, each partner tries to change

the other one over to his own way of thinking and his own emotional attitudes.

If these assumptions are reasonably correct, we can raise the question whether all of the major problems described in American marriages should be considered symptoms of neurosis. I would be the first to agree with Dr. Ruskin that frequently neurotics marry one another and then continue the elaboration of their respective neuroses in the interaction of that relationship. However, it would seem fair to say that many reasonably healthy people have difficulties which can be explained on the basis of serious discrepancies in their respective cultural backgrounds and their different value systems. This is important from a therapeutic standpoint, because it implies that relatively short term psychotherapy and counseling may produce surprisingly good results.

As regards persons with more full-fledged neuroses, Dr. Ruskin has given a very good description of a practical approach which has apparently proved successful in his hands. It is worth noting that not all psychiatrists are sufficiently eclectic and flexible to utilize this form of approach. However, I think that we would all agree that frequently it is ideal from a therapeutic standpoint to treat the family rather than the individual. Unfortunately practical considerations of time, of money and of resistance on the part of certain members of the family often

make this impossible. Probably most psychiatrists usually have to content themselves with treating the member who is "hurting" the most at the time. Yet we have all had the experience over and over again of treating the patient with the most obvious symptoms while recognizing that the marital partner or the parent, as the case may be, is the one who is the real pathogenic source in the family constellation. Fortunately, helping the patient may have considerable beneficial effect on the untreated partner.

One final point: The orthodox psychoanalytic point of view seems to be that the same therapist should never treat both marital partners, but rather refer one to a colleague. The more flexible psychoanalysts now seem to feel that if one partner is undergoing intensive therapy, the other may be seen occasionally for auxiliary consultation but never for analytic treatment. I feel very strongly that with proper techniques it is indeed possible for the same therapist to treat, intensively, both members of the marital partnership. It involves, of course, special techniques in handling different phases of the relationship, particularly those which are sometimes termed "transference" and "countertransference." On the other hand, it enables the therapist to get additional valuable data about the respective problems of each spouse and to function as a unifying force in the marital conflict.

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